

## Durham Research Online

---

### Deposited in DRO:

24 June 2013

### Version of attached file:

Published Version

### Peer-review status of attached file:

Peer-reviewed

### Citation for published item:

Labonté, Ronald and Schrecker, Ted (2007) 'Foreign policy matters : a normative view of the G8 and population health.', Bulletin of the world health organization., 85 (3). pp. 185-191.

### Further information on publisher's website:

<http://dx.doi.org/10.2471/BLT.06.037242>

### Publisher's copyright statement:

### Additional information:

Table of contents for the journal available at <http://www.who.int/bulletin/volumes/85/3/en/index.html>

---

## Use policy

The full-text may be used and/or reproduced, and given to third parties in any format or medium, without prior permission or charge, for personal research or study, educational, or not-for-profit purposes provided that:

- a full bibliographic reference is made to the original source
- a [link](#) is made to the metadata record in DRO
- the full-text is not changed in any way

The full-text must not be sold in any format or medium without the formal permission of the copyright holders.

Please consult the [full DRO policy](#) for further details.

# Foreign policy matters: a normative view of the G8 and population health

Ronald Labonte<sup>a</sup> & Ted Schrecker<sup>a</sup>

**Abstract** The Group of Eight (G8) countries occupy a dominant position in the international economic and political order. Given what is known about influences on the social determinants of health in an interconnected world, the G8 are a logical starting point for any enquiry into the relations between foreign policy and health.

We first make five arguments for adopting an explicitly normative, equity-oriented perspective on the performance of G8 policy in areas related to population health. We then examine G8 performance with respect to the crucial policy triad of development assistance, debt relief and trade, finding that neither rhetoric nor promising institutional innovation has been matched by resources commensurate with demonstrated levels of need.

We conclude that it is necessary to pursue advocacy efforts based on the normative perspective we have put forward and that doing so effectively requires further investigation of why some polities are more receptive than others to policies of redistribution both within and outside their borders.

Bulletin of the World Health Organization 2007;85:185-191.

Une traduction en français de ce résumé figure à la fin de l'article. Al final del artículo se facilita una traducción al español. الترجمة العربية لهذه الخلاصة في نهاية النص الكامل لهذه المقالة.

## Introduction

The Group of Eight (G8) countries “account for 48% of the global economy and 49% of global trade, hold four of the United Nations’ five permanent Security Council seats, and boast majority shareholder control over the International Monetary Fund and the World Bank.”<sup>1</sup> The G8 provide roughly 75% of the world’s development assistance; their deep pockets, organizational resources and superior bargaining power provide them with formidable advantages in trade negotiations and dispute-resolution proceedings. The G8 “lacks the two main characteristics of more structured international governmental organizations ... : a constitutive intergovernmental agreement, and a secretariat.”<sup>2</sup> Nevertheless, the Group’s annual summits and periodic ministerial meetings have emerged as important forums for coordinating social and economic policy. Above and beyond policy and resource commitments, annual G8 summits “have value in establishing new principles in normative directions, in creating and highlighting issue areas and agenda items, and in altering the publicly allowable discourse used.”<sup>3</sup>

Social determinants of health, of which health care is only one, are af-

fectured by social and economic policy choices made outside the health sector, notably “those central engines in society that generate and distribute power, wealth and risk.”<sup>4</sup> Globalization is a key influence on those processes, and major “asymmetries” of power and resources between rich and poor countries characterize the institutions of globalization and the resulting distribution of gains, losses and policy autonomy.<sup>5</sup> In an interconnected world, influences on the social determinants of health cannot be understood in isolation from those asymmetries and the policy choices in which they originate.<sup>6–8</sup> The G8’s economic and political power makes it a logical starting point for any such enquiry.

In this article, we articulate an explicitly normative perspective on how the policies of G8 countries affect population health outside their borders. We then examine G8 policies in three areas — development assistance, debt relief and trade policy — that represent major channels of influence on the resources available in developing countries to meet basic health-related needs. Despite promising initiatives, G8 performance has been inadequate when viewed against demonstrated levels of need and against an emerging consensus in the

relevant policy communities on how best to meet those needs. Those of us concerned with global health equity must intensify advocacy efforts directed at the G8. To be effective, we must also increase efforts to understand what elements of the domestic political context within G8 countries make some government leaders, and some polities, more receptive to such efforts.

## The G8 and global health: why care?

Mainstream perspectives on international relations are sceptical about applying ethical criteria to the actions of national governments, viewing expectations that they will be driven by considerations other than national self-interest as unrealistic. An alternative view is gaining prominence: “Global actors and institutions, whether they act bilaterally (especially direct overseas development assistance, trade agreements) or multilaterally (through, e.g., the United Nations system, World Bank or International Monetary Fund), are obligated to remedy global inequalities that exist in affluence, power, and social, economic and political opportunities”.<sup>9</sup> As applied to the G8, at least five arguments for this view can be identified.

<sup>a</sup> Institute of Population Health, University of Ottawa, 1 Stewart Street, Ottawa, Ontario K1N 6N5, Canada. Correspondence to Ted Schrecker (email: tschrecker@sympatico.ca).

Ref. No. 06-037242

(Submitted: 3 October 2006 – Final revised version received: 18 December 2006 – Accepted: 20 December 2006)

First, the G8 themselves are committed to “make globalization work for all [their] citizens and especially the world’s poor.”<sup>10</sup> At a minimum, this means the G8 are committed to improving the ability of the world’s poor, however defined, to meet basic health-related needs.

Second, the international community, as represented by the UN General Assembly, has committed support to achieving the Millennium Development Goals (MDGs) by specified target dates, usually the year 2015. Three MDGs are explicitly health-related (<http://www.un.org/millenniumgoals/>); others directly address crucial determinants of (ill) health: extreme poverty, under nourishment, living in slums, subordination of women and lack of access to education, safe water and basic sanitation. The goals and targets are ambitious relative to the size of the challenge, yet modest in terms of, for instance, their aspirations for reducing absolute poverty and improving the lives of slum dwellers. In several regions of the world the MDGs will not be met in the absence of greatly intensified policy efforts on the part of the industrialized world.<sup>11–13</sup> Both because of the need for such efforts and because choices made by governments in many developing countries have been constrained by global economic institutions and markets, it is *prima facie* reasonable to assign the G8 a substantial share of responsibility for this failure.

Third, the disparity between the resources available to the world’s affluent minority and the modest cost of medical and public health interventions that would save millions of lives per year may be regarded as ethically reprehensible; this is because simple arithmetic suggests that it is so easily avoidable<sup>14</sup> and because the basic needs of hundreds of millions of people remain unmet while the winners in the global economy enjoy unprecedented opportunities for luxury consumption.

Fourth, in an interconnected world it is reasonable to search for past and current causal responsibility (who makes what happen?) for such disparities in the patterns of interconnection. Philosopher Thomas Pogge expands this argument with specific reference to the global persistence of poverty,<sup>15,16</sup> which undoubtedly cuts off the opportunity to lead a healthy life.<sup>17</sup> He argues that “our failure to make a serious effort towards poverty reduction may constitute not

merely a lack of beneficence, but our active impoverishing, starving, and killing millions of innocent people by economic means.”<sup>15</sup>

Fifth, the two immediately preceding arguments assume special significance in the context of international human rights law. Key elements include the right to an adequate standard of living as outlined under Article 25 of the 1948 Universal declaration of human rights; the right in Article 28 “to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized,” which some commentators read as creating clear cross-border obligations; and national obligations “to respect, protect and fulfil” the right to health set out in the 1966 International covenant on economic, social and cultural rights.<sup>18</sup> Although no effective supranational mechanisms now exist to ensure respect for these requirements, they cannot be dismissed as a source of obligations, and they are the focus of increased attention within the UN system.<sup>19</sup>

## Rating the G8

Choices about official development assistance, debt relief and trade policy decisively influence both the volume of resources available to meet basic needs in much of the developing world and the domestic policy environment for meeting those needs.<sup>6–8</sup> This policy triad is therefore essential subject matter for rating the G8’s performance with respect to population health.

Many developing countries’ spending on health is only a fraction of the amount needed to provide basic health services; ironically, the poorest countries tend to be those where the proportion of out-of-pocket health-care expenditure is highest.<sup>20</sup> Even with the most optimistic assumptions, many countries cannot remedy this situation without more, and more predictable, inflows of official development assistance, sometimes for 20 years or longer.<sup>20</sup> Estimates of the value of additional official development assistance needed to meet the health MDGs range from US\$ 25 billion to US\$ 70 billion per year between (roughly) 2005 and 2015; official development assistance for health as of 2004 was approximately US\$ 12 billion.<sup>20,21</sup> The Commission for Africa established by the United Kingdom in advance of the 2005 G8 summit<sup>22</sup> and the UN Millennium

Project<sup>23</sup> concluded that the industrialized world needs approximately to double its spending on official development assistance as a necessary, although not sufficient, condition for achieving the entire suite of MDGs.

## Development assistance

In 2005, the G8 countries promised a US\$ 25 billion increase in annual official development assistance for Africa by 2010 (thus doubling their present level of assistance), driven primarily by the pledge of the European Union to raise members’ aid spending to a long-standing UN target of 0.7% of gross national income. Canada, Japan and the United States offered increases in aid levels but did not commit to reaching the target, and all G8 countries currently lag behind some non-G8 countries that have exceeded the 0.7% target consistently (Fig. 1). Official development assistance for 2005 included one-off debt cancellations for strategically important and oil-rich Iraq and Nigeria; however, without further new commitments, spending may actually decline in 2007 and may have done so in 2006 (data are not yet available).<sup>24</sup> The Global Fund to Fight AIDS, Tuberculosis and Malaria, the G8’s flagship global health programme when it was announced, remains drastically under funded and precariously reliant on short-term financing.<sup>25</sup> Even if commitments for official development assistance to Africa are fulfilled, questions remain about the future of health equity elsewhere in the developing world; more than 70% of the world’s most desperately poor people, as defined by the World Bank’s admittedly contentious poverty line of US\$ 1.00 per day,<sup>26</sup> live outside Africa (there are 100 million more such people in south Asia alone than there are in Africa).<sup>27</sup>

To answer predictable criticisms, it must be emphasized that official development assistance is not a panacea. Major improvements are needed in the quality of administration (in both donor and recipient countries) and the purposes for which aid is used. According to the UN Millennium Project, just 14% of aid in low-income countries, and 27% in middle-income countries, directly supports meeting MDGs;<sup>23</sup> a useful if imperfect indicator of how much aid meets basic needs. That project and other large-scale research syntheses have shifted the burden of proving the need for increased aid away from proponents;<sup>22</sup> it now must

Ronald Labonte & Ted Schrecker

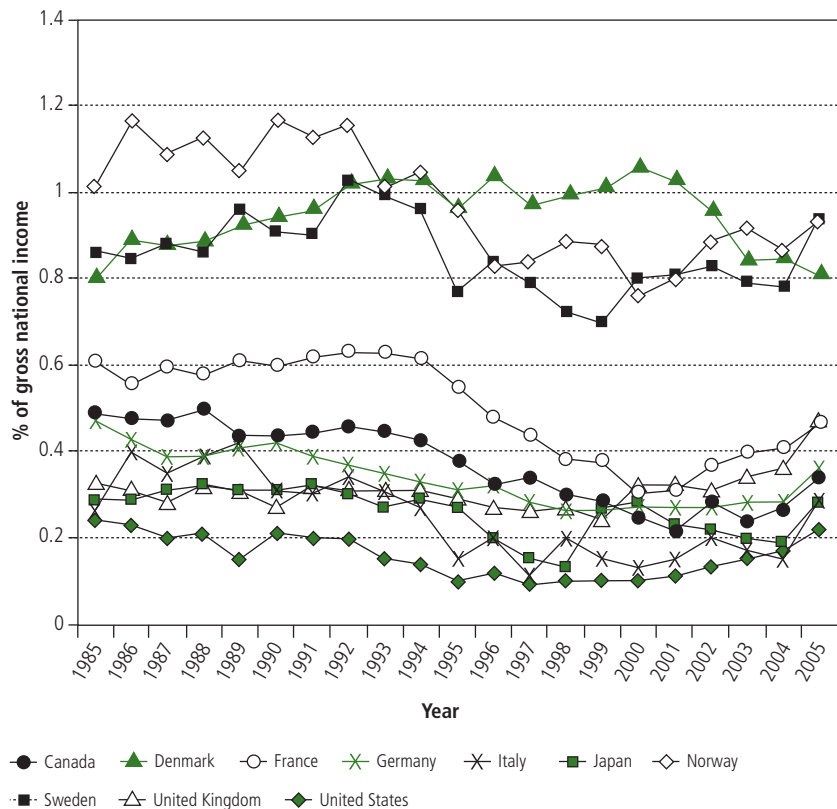
be met by those who maintain fiscally convenient scepticism about the value of aid. Further, efforts to improve the effectiveness of aid must de-emphasize evaluating the recipient countries using buzzwords like “good governance” and “absorptive capacity” and instead focus on donors’ policies (tied aid, multiple and complex reporting requirements, short-term financial commitments, priorities unrelated to basic needs and public expenditure budget ceilings) that create inefficiencies in the deployment of aid and prevent it from being used appropriately in ways that contribute to health equity.

### Debt relief

External debt has been recognized for almost 20 years as undermining the ability of developing countries to meet basic needs.<sup>28,29</sup> It is perhaps the single most fundamental constraint on aid effectiveness: in every region of the developing world except sub-Saharan Africa, financial outflows to service external debt consistently exceed the inflow of development assistance (Fig. 2). The G8 took the lead in partially cancelling the external debts of some of the world’s poorest countries through the Heavily Indebted Poor Countries Initiative, making possible increases in public spending on health and education in several recipient countries.<sup>30</sup> The initiative’s progress towards meeting basic needs and reducing debt burdens has nevertheless been inadequate.<sup>31</sup> Many countries saw only modest decreases in their debt-service obligations, and three actually saw increases as of 2005.<sup>32</sup> Like the promised increases in official development assistance, the 2005 summit commitment to additional multilateral debt cancellation for 18 heavily indebted poor countries that have reached their “completion point” — the commitment now known as the Multilateral Debt Relief Initiative — was welcome and overdue.

However the 2005 and 2006 summits left crucial issues unresolved. The countries eligible for multilateral debt relief are not the countries where a majority of the world’s poor live; many other low- and middle-income countries will require substantial debt relief to achieve the MDGs.<sup>23,33</sup> Debt “sustainability” for countries eligible for multilateral debt relief continues to be defined in a way that gives priority to repaying creditors. An alternative definition of sustainability

Fig. 1. Trends in providing development assistance for G8<sup>a</sup> countries and selected comparison countries, 1985–2005



<sup>a</sup>The Russian Federation is not a significant aid donor.

Source: Organisation for Economic Cooperation and Development, Development Database on Aid from Development Assistance Committee Members (<http://stats.oecd.org/wbos/default.aspx?DatasetCode=TABLE1>); 2005 figures from OECD Development Assistance Committee.<sup>60</sup>

works backward from estimates of the minimum public expenditure required to meet basic needs and only then determines how much (if any) of the public budget should be devoted to debt repayment; this approach implies a need for far more extensive debt cancellation.<sup>23,33,34</sup> Under the Multilateral Debt Relief Initiative, as under its predecessor initiative, in order to have their debts cancelled countries must comply with macroeconomic conditionalities recommended by international financial institutions; this is arguably a reprise of earlier, highly destructive “structural adjustment” programmes. Conditions may include further import liberalization<sup>35</sup> and controversial public expenditure ceilings that limit governments’ ability to deliver health services and education.<sup>36,37</sup> Finally, the question remains why “odious debts” incurred by highly repressive or corrupt governments without the consent of their citizens should be regarded as collectable under international law.<sup>38</sup> One study calculates that US\$ 726 billion of the current debt of 13

developing countries is odious, and 10 countries should actually receive refunds of US\$ 383 billion in past payments on such debts.<sup>39</sup>

### Trade liberalization

Trade is the third element to be considered. Main actors in development policy who disagree about much else nonetheless agree that improving market access for exports from developing countries is crucial to stimulating the economic growth that can support poverty reduction and associated improvements in the social determinants of health. However, important disagreements persist about the viability of export-oriented growth strategies and about how equitably their benefits are distributed. The research literature and many governments in developing countries attach special importance to eliminating the agricultural subsidies that lower world prices and limit export opportunities for developing countries,<sup>22,40</sup> although the actual magnitude and distribution of benefits from agricultural trade liberalization

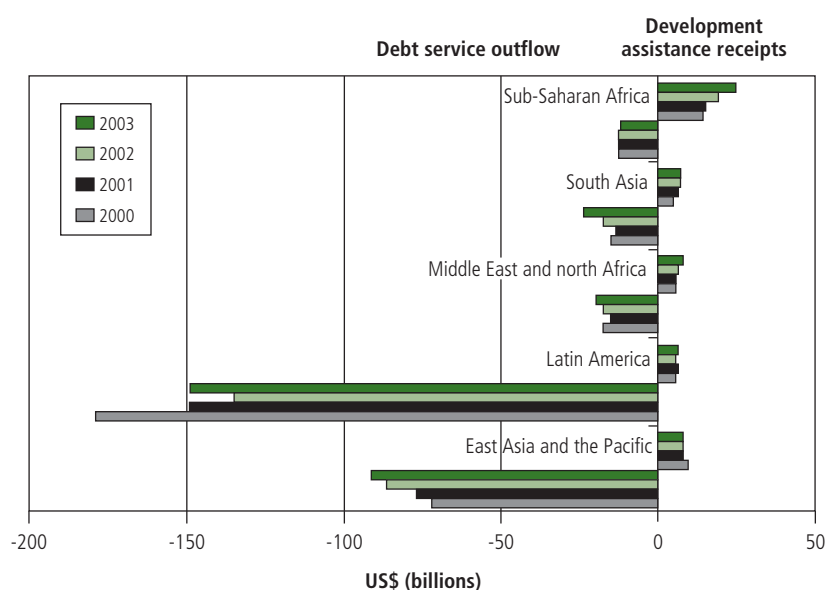


remain contentious.<sup>41</sup> World Trade Organization (WTO) negotiations begun at Doha in 2001 were promoted as a “development round” in which the concerns of developing countries, including agricultural subsidies, would be given priority. The 2006 summit’s 16 July “call for a concerted effort to conclude the negotiations of the WTO’s Doha Development Agenda ... and to fulfil the development objective of the Round” echoed similar exhortations from previous summits. On 24 July, negotiations reached an impasse over the issue of agricultural subsidies. Initial reports blamed the resistance of the United States and some countries of the European Union; perhaps expectations for the Doha round were always too high<sup>42</sup> but failure of G8 leadership is nevertheless evident.

As a result, industrialized countries may now emphasize bilateral or regional negotiations where disparities in bargaining power and resources are even greater than in the WTO context. The G8 agreed in 2005 that developing countries must “decide, plan and sequence their economic policies to fit with their own development strategies”,<sup>43</sup> but negotiating strategies and policy positions taken by member countries often do not respect this imperative. Even if policy instruments to support domestic producers that industrialized countries routinely used on their path to wealth remain permissible under current WTO rules,<sup>44</sup> they are precluded by commitments in an expanding number of bilateral and regional agreements.<sup>45</sup> Illustrating the danger, a growing number of trade treaties with the United States contain clauses<sup>46</sup> that undermine hard-won flexibilities in interpreting the agreement on Trade-related aspects of intellectual property rights (also known as TRIPS) in order to protect access to essential medicines.

Trade policy lends itself uneasily to incorporating such distributional considerations. Stiglitz and Charlton have pointed out that the development round of trade negotiations requires moving from a “mercantilist” orientation, involving parties with highly unequal resources and asymmetrical bargaining power, towards “a collectively agreed global social welfare function. However, there has been almost no discussion, let alone agreement, on what that function should be”.<sup>47</sup> Although this implies a major value shift, a clear commitment to resource transfers from rich countries to poor countries may also be a practical

Fig. 2. Debt service and development assistance, by region, 2000–2003



Source: World Bank Data from Econstats (<http://www.econstats.com/wb/V392.htm> and <http://www.econstats.com/wb/V546.htm>).

prerequisite for reviving WTO negotiations after the July 2006 failure.<sup>48</sup>

## Health equity: beyond realism?

On the one hand, the G8 have demonstrated their effectiveness as an alternative to WHO and other multilateral organizations in addressing global health issues, through such initiatives as the Global Fund.<sup>49</sup> On the other hand, neither rhetoric nor promising institutional innovation has been matched by resources commensurate with demonstrated levels of need. For some observers, this is not surprising and indeed it is utopian to expect different outcomes, yet unless a collective shrug is viewed as an adequate response to millions of easily preventable deaths per year<sup>50</sup> more must be demanded from the G8. The questions are what and how.

One answer would be to expand the G8 into a larger club modelled on the Group of 20 finance ministers (known as the G20), which includes such emerging economies as Argentina, Brazil, China, India, Indonesia, Mexico, the Republic of Korea, Saudi Arabia, South Africa and Turkey. This would reflect their growing global importance as they are integrated into production networks and capital markets, and bring to the table countries that account for 60% of the world’s population rather than the

14% accounted for by the members of the G8.<sup>51</sup> Yet the self-description of the G20 (on their web site) as comprising “systemically significant” economies raises the question of how systemically insignificant countries — including the entire African continent, except South Africa, and Nordic countries that consistently lead the industrialized world in their commitment to official development assistance (Fig. 2) — would be represented. The paradox here is that an apparently more inclusive structure actually implies deeper division between the included and the excluded.

A second approach, exemplified by health equity agendas,<sup>52</sup> focuses on policy content. In our North American experience, understanding how social determinants of health are affected by policy choices outside the health sector and half a world away is highly limited even among otherwise sophisticated decision-makers and researchers. In Europe, recognition of the need to consider the health impacts of such policies is more advanced, as reflected in the Finnish presidency of the European Union, which took the theme of “health in all policies”. Nevertheless, the key background document for this initiative<sup>53</sup> confined its analysis to impacts within countries of the European Union. Therefore, the consequences of G8 policies for health outside the industrialized world represent a theme of special

importance for analysis and advocacy, especially in situations where, as it now appears will be the case for the 2007 G8 summit, health per se is not prominent on the agenda.

Policies in areas such as trade, debt relief and official development assistance unavoidably interact and must not operate at cross purposes; yet, although policy coherence is important,<sup>54</sup> a more fundamental issue involves the values around which policy coheres. A high degree of policy coherence already exists among, for example, the economic interests of producers in industrialized countries and the promotion of import liberalization by the World Bank, the International Monetary Fund and the WTO. The effects may be destructive in terms of the determinants of health. Conversely, Norway's 2006 declaration on international policy embodies quite a different set of values, committing Norway to, for example, oppose development conditionalities that promote privatization and to support only trade

policies that will not prevent poorer countries from developing into "welfare societies" like Norway's.<sup>55</sup>

Can and will the richest and most powerful countries similarly promote what Michael Marmot, chair of WHO's Commission on Social Determinants of Health, calls "a vision of the world where people matter and social justice is paramount"?<sup>56</sup> Because the G8 are formal democracies, this question must ultimately be asked not of leaders but of their electorates. Levels of official development assistance are highly imperfect proxies for an equity-oriented approach to foreign policy, but the persistent fourfold difference among industrialized countries in aid commitments (Fig. 1) is clearly relevant. As predicted by research describing the relation between national policies on domestic welfare and levels of development assistance,<sup>57</sup> an inverse correlation exists across many countries between the percentage of gross national income allocated to development assistance and internationally standardized

child poverty rates.<sup>58</sup> It is important, then, not only to demonstrate clearly the links between foreign policy and health in countries half a world away, but also to ask why some industrialized countries appear markedly more receptive than others to the redistribution of resources both within and across their borders. The answers are crucial to advocating more effectively for global health equity. Invoking differences in political culture substitutes description for explanation;<sup>59</sup> advocates for health equity must ask where political culture comes from and how it can be changed. ■

**Funding:** The authors' earlier research on the G8 and global health was supported by the International Development Research Centre (Canada) and the Canadian Institutes of Health Research. No funding was received for the preparation of this article.

**Competing interests:** None declared.

## Résumé

### Politique étrangère : point de vue normatif pour l'évaluation des résultats des interventions du G8 sur la santé publique

Les pays du G8 occupent une position dominante sur la scène économique et politique. Au vu de ce que l'on sait de son influence sur les déterminants sociaux de la santé dans un monde, le G8 peut être considéré comme le point de départ logique de tout défaut d'équité dans les relations entre politique étrangère et santé.

Nous avons formulé cinq arguments en faveur de l'adoption d'un point de vue explicitement normatif et axé sur l'équité pour évaluer les résultats du G8 dans les domaines liés à la santé publique. Nous avons ensuite examiné ces résultats sous l'angle des trois composantes politiques clés suivantes : aide au

développement, allègement de la dette et commerce, et nous avons constaté qu'aucune innovation prometteuse, ni sur le plan théorique, ni sur le plan institutionnel, n'avait été obtenue par des ressources en rapport avec l'ampleur des besoins démontrés.

En conclusion, il faut poursuivre les efforts pour promouvoir le point de vue normatif proposé et pour que cette promotion soit efficace, il faut étudier plus avant les raisons amenant certaines politiques étrangères à être plus réceptives que d'autres aux politiques de redistribution à l'intérieur et à l'extérieur de leurs frontières.

## Resumen

### La política exterior importa: una perspectiva normativa del G8 y la salud de la población

Los países del Grupo de los Ocho (G8) ocupan una posición dominante en el orden económico y político internacional. Considerando lo que hoy sabemos sobre las influencias en los determinantes sociales de la salud en un mundo interconectado, el G8 es un punto de partida lógico para cualquier investigación sobre las relaciones entre política exterior y salud.

En primer lugar aportamos cinco argumentos para adoptar una perspectiva explícitamente normativa y orientada a la equidad sobre el funcionamiento de las políticas del G8 en ámbitos relacionados con la salud de la población. A continuación examinamos el desempeño del G8 respecto de una tríada crucial

en materia de políticas: la asistencia para el desarrollo, el alivio de la carga de la deuda y el comercio, y hallamos que ni las declaraciones ni las prometedoras innovaciones institucionales se han visto igualadas por unos recursos proporcionales a los niveles de necesidad observados.

Nuestra conclusión es que es necesario emprender actividades de promoción basadas en la perspectiva normativa que hemos propuesto, y que para actuar eficazmente en ese sentido es preciso seguir investigando por qué algunos sistemas de gobierno son más sensibles que otros a las políticas de redistribución tanto dentro como fuera de su territorio.

## ملخص

### السياسة الخارجية هامة: نظرة معيارية لمجموعة البلدان الثمانية ولصحة السكان

الثلاثية السياسية الرئيسية وهي المساعدات التنموية والإعفاء من الديون والتجارة. وقد وجدنا أن كلاً من المبادرات المرتجلة والمبادرات المؤسسية التي يجرى فعلها لم تخصص لها الموارد التي اتفق عليها ضمن مستويات مثبتة من الحاجة. واستنتجنا أن من الضروري متابعة جهود التوعية المستندة على وجهات النظر المعيارية التي وضعناها سابقاً، وأن تحقيق ذلك يقتضي المزيد من الدراسات حول سبب قبول بعض السياسات أكثر من غيرها سواء ضمن حدود بلدانها أم خارج تلك الحدود.

تشغل مجموعة البلدان الثمانية موقعاً هاماً في النظام الاقتصادي والسياسي العالمي. ونظراً لما هو معروف عن تأثيرات المحددات الاجتماعية للصحة في عالم مترابط الأرجاء، فإن مجموعة البلدان الثمانية الكبرى تعد بداية منطقية لأي استفسار عن العلاقة بين السياسة الخارجية والصحة.

وقد بدأنا بخمسة منطلقات لثنائي وجهات نظر معيارية بشكل واضح، وذات توجه نحو العدالة والمساواة وتتناول الأداء في سياسات مجموعة البلدان الثمانية في مواضيع تتعلق بصحة السكان. ثم درسنا أداء مجموعة البلدان الثمانية في

## References

1. Corlazzoli V, Smith J, eds. *The G8 and Africa final report: an overview of the G8's ongoing relationship with African development from the 2001 Genoa summit to the 2005 Gleneagles summit*, 2005. Available from: [http://www.g8.utoronto.ca/evaluations/csed/g8africa\\_050624.html](http://www.g8.utoronto.ca/evaluations/csed/g8africa_050624.html) (Civil Society and Expanded Dialogue Unit, G8 Research Group, University of Toronto.)
2. Hajnal PI. *Civil society's growing role vis-à-vis the G7/G8*, 2005. Available from: [http://en.civilg8.ru/Civil\\_and\\_G8/1647.php](http://en.civilg8.ru/Civil_and_G8/1647.php)
3. Kirton J, Kokotsis E, Corlazzoli V, Varey M, Rath A, Sunderland L. *Gleneagles final compliance report, July 8, 2005, to June 1, 2006*, 2006. Available from: <http://www.g8.utoronto.ca/2005g8compliance060612c.pdf> (G8 Research Group, University of Toronto.)
4. Diderichsen F, Evans T, Whitehead M. The social basis of disparities in health. In: Whitehead M, Evans T, Diderichsen F, Bhuiya A, Wirth M, eds. *Challenging inequities in health: from ethics to action*. New York: Oxford University Press; 2001:12-23.
5. Birdsall N. *Stormy days on an open field: asymmetries in the global economy*, 2006. Helsinki: World Institute for Development Economics Research; 2006. (WIDER Research Paper 2006/31.) Available from: <http://www.wider.unu.edu/publications/rps/rps2006/rp2006-31.pdf> (Research paper No. 2006/31.)
6. Labonte R, Schrecker T, Sanders D, Meeus W. *Fatal indifference: the G8, Africa and global health*. Cape Town: University of Cape Town Press; 2004.
7. Labonte R, Schrecker T. Committed to health for all? How the G7/G8 rate. *Soc Sci Med*. 2004;59:1661-1676.
8. Labonte R, Schrecker T. The G8 and global health: What now? What next? *Can J Public Health* 2006;97:35-38.
9. Ruger JP. Ethics and governance of global health inequalities. *J Epidemiol Commun Health* 2006;60:998-1002.
10. G8. *Communiqué: Genova, July 22, 2001*, 2001. Available from: <http://www.g8.utoronto.ca/summit/2001genoa/finalcommuniqué.html> (G8 Information Centre, University of Toronto.)
11. Wagstaff A, Claeson M, Abrantes A, Alban A, Axelsson HB, Baingana F et al. *The Millennium Development Goals for health: rising to the challenges*. Washington, DC: World Bank; 2003.
12. United Nations. *The Millennium Development Goals report*. New York: United Nations; 2005.
13. World Health Organization. *Health and the Millennium Development Goals*. Geneva: WHO; 2005.
14. Pogge T. Human rights and global health: a research program. *Metaphilosophy* 2005;36:182-209.
15. Pogge T. Priorities of global justice. *Metaphilosophy*. 2001;32:6-24.
16. Pogge T. Severe poverty as a violation of negative duties. *Ethics Int Aff* 2005; 19:55-83.
17. Paluzzi JE, Farmer PE. The wrong question. *Development* 2005;48:12-18.
18. Nygren-Krug H. *25 questions and answers about health and human rights*. Geneva: World Health Organization; 2002.
19. Office of the United Nations High Commissioner for Human Rights. *Special Rapporteur of the Commission on Human Rights on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, 2002. Available from: <http://www.ohchr.org/english/issues/health/right/>
20. Gottret P, Schieber G. *Health financing revisited: a practitioner's guide*. Washington, DC: World Bank; 2006.
21. Schieber G, Fleisher L, Gottret P. Getting real on health financing. *Finance Dev* [online journal] 2006;43 (December). Available from: <http://www.imf.org/external/pubs/ft/fandd/2006/12/schieber.htm>
22. Commission for Africa. *Our common interest: report of the Commission for Africa*. London: Commission for Africa; 2005.
23. United Nations Millennium Project. *Investing in development: a practical plan to achieve the Millennium Development Goals*. London: Earthscan; 2005.
24. United Nations. *International financial system and development: report of the Secretary-General*, 2006. Available from: <http://www.un.org/esa/ffd/indexDocuments.htm> (Document No. A/61/136.)
25. Banati P, Greene B, Ferazzi S. *Funding the global fight against HIV/AIDS, tuberculosis and malaria: resource needs for the Global Fund, 2006-2007 and 2008-2010*. Geneva: Global Fund to Fight AIDS, Tuberculosis and Malaria; 2006. Available from: [http://www.theglobalfund.org/en/files/about/replenishment/resource\\_needs\\_2006.pdf](http://www.theglobalfund.org/en/files/about/replenishment/resource_needs_2006.pdf)
26. Reddy SG, Pogge TW. *How not to count the poor*, 2005. Available from: <http://www.socialanalysis.org>
27. Chen S, Ravallion M. How have the world's poorest fared since the early 1980s? *World Bank Res Obs* 2004;19:141-69.
28. Cornia GA, Jolly R, Stewart F, eds. *Adjustment with a human face. Vol 1: Protecting the vulnerable and promoting growth*. Oxford: Clarendon Press; 1987.
29. Cheru F. *Economic, social and cultural rights: effects of structural adjustment policies on the full enjoyment of human rights*, 1999. Available from: <http://www.unhcr.ch/Huridocda/Huridoca.nsf/TestFrame/f991c6c62457a2858025675100348aef?OpenDocument> (Document No. E/CN.4/1999/50.)
30. Gupta S, Clements B, Guin-Siu MT, Leruth L. Debt relief and public health spending in heavily indebted poor countries. *Bull World Health Organ* 2002; 80:151-7.
31. United Nations Secretary-General. *Recent developments in external debt: report of the Secretary-General*, 2006. Available from: <http://daccessdds.un.org/doc/UNDOC/GEN/N06/432/22/PDF/N0643222.pdf?OpenElement> (Document No. A/61/152.)
32. United Nations Department of Economic and Social Affairs. *World Economic and Social Survey 2005: financing for development*. New York: United Nations; 2005. (Document No. E/2005/51/Rev.1, ST/ESA/298.)
33. Mandel S. *Debt relief as if people mattered: a rights-based approach to debt sustainability*. London: New Economics Foundation; 2006. Available from: [http://www.neweconomics.org/gen/z\\_sys\\_publicationdetail.aspx?pid=223](http://www.neweconomics.org/gen/z_sys_publicationdetail.aspx?pid=223)
34. United Nations. *In larger freedom: towards development, security and human rights for all: report of the Secretary-General*. New York: United Nations; 2005. Available from: <http://www.un.org/largerfreedom/contents.htm>
35. Brock K, McGee R. *Mapping trade policy: understanding the challenges of civil society participation*. Brighton: Institute for Development Studies, University of Sussex; 2004. (IDS Working Paper 225.) Available from: <http://www.ids.ac.uk/ids/bookshop/wp/wp225.pdf#search=%22%20%22%20%20Mapping%20Trade%20Policy%3A%20Understanding%20the%20Challenges%22%22>
36. Ooms G, Schrecker T. Viewpoint: expenditure ceilings, multilateral financial institutions, and the health of poor populations. *Lancet* 2005;365:1821-3.
37. Wood A. *IMF macroeconomic policies and health sector budgets*. Amsterdam: Wemos Foundation; 2006. Available from: [http://www.wemos.nl/Documents/wemos\\_synthesis\\_report.pdf](http://www.wemos.nl/Documents/wemos_synthesis_report.pdf)

38. Khalfan A, King J, Thomas B. *Advancing the odious debt doctrine*. Montréal: Centre for International Sustainable Development Law; 2003. Available from: <http://www.cisdsl.org/pdf/debtentire.pdf>
39. Mandel S. *Odious lending: debt relief as if morals mattered*. London: New Economics Foundation; 2006. Available from: <http://www.jubileersearch.org/news/Odiouslendingfinal.pdf>
40. Watkins K, Fowler P. *Rigged rules and double standards*. Washington, DC: Oxfam International; 2002. Available from: [http://www.maketradeair.org/assets/english/report\\_english.pdf](http://www.maketradeair.org/assets/english/report_english.pdf)
41. Birdsall N, Rodrik D, Subramanian A. How to help poor countries. *Foreign Aff* 2005;84:136-52.
42. Ricupei R. The paradoxes and contradictions of world trade. *BRIDGES Monthly Review* 2006;10:17-20.
43. G8. *The Gleneagles communiqué*, 2005. Available from: <http://www.g8.utoronto.ca/summit/2005gleneagles/communique.pdf> (G8 Information Centre, University of Toronto.)
44. Di Caprio A, Amsden A. *Does the new international trade regime leave room for industrialization policies in the middle-income countries?* Geneva: Policy Integration Department, World Commission on the Social Dimension of Globalization, International Labour Office; 2004. (Working Paper No. 22.)
45. Shadlen KC. Exchanging development for market access? Deep integration and industrial policy under multilateral and regional-bilateral trade agreements. *Review of International Political Economy* 2005;12:750-75.
46. Fink C, Reichenmiller P. *Tightening TRIPS: the intellectual property provisions of recent US free trade agreements*. Washington, DC: World Bank; 2005. (Trade Note 20.) Available from: <http://siteresources.worldbank.org/INTRANETTRADE/Resources/Pubs/TradeNote20.pdf#search=%22%20%22Tightening%20TRIPS%3A%20The%20Intellectual%20Property%22%20%22World%20Bank%22%22>
47. Stiglitz J, Charlton AH. Common values for the development round. *World Trade Review* 2004;3:495-506.
48. Collier P. Why the WTO is deadlocked: and what can be done about it. *The World Economy* 2006;29:1423-49.
49. Kirton J, Mannell J. *The G8 and global health governance*, 2005. Available from: [http://www.g8.utoronto.ca/scholar/kirton2005/kirton\\_waterloo2005.pdf](http://www.g8.utoronto.ca/scholar/kirton2005/kirton_waterloo2005.pdf) (G8 Research Group, University of Toronto.)
50. Bryce J, Black RE, Walker N, Bhutta ZA, Lawn JE, Steketee RW. Can the world afford to save the lives of 6 million children each year? *Lancet* 2005; 365:2193-2200.
51. Bradford CI. Anticipating the future: a political agenda for global economic governance. In: English J, Thakur R, Cooper AF, eds. *Reforming from the top: a leaders' 20 summit*. Tokyo: United Nations University Press; 2005:46-62.
52. Labonte R, Schrecker T, Sen Gupta A. A global health equity agenda for the G8 summit. *BMJ* 2005;350:533-6.
53. Ståhl T, Wismar M, Ollila E, Lahtinen E, Leppo K, eds. *Health in all policies: prospects and potentials*. Helsinki: Ministry of Social Affairs and Health; 2006.
54. Cheru F, Bradford CI. The planet at risk: mobilizing resources for global human security. In: Helsinki Process Secretariat, ed. *Helsinki process papers on global economic agenda*. Helsinki: Foreign Ministry of Finland; 2005:9-61. Available from: [http://www.helsinki.fi/netcomm/ImgLib/24/89/helsinki\\_process\\_publication\\_series\\_3\\_2005.pdf](http://www.helsinki.fi/netcomm/ImgLib/24/89/helsinki_process_publication_series_3_2005.pdf)
55. Government of Norway, Office of the Prime Minister. *The Soria Moria Declaration on International Policy. Chapter 2: international policy*, 2006. Available from: <http://odin.dep.no/smk/english/government/government/001001-990363/dok-bn.html>
56. Marmot M. Social determinants of health inequalities. *Lancet* 2005; 365:1099-1104.
57. Noël A, Therien J-P. From domestic to international justice: the welfare state and foreign aid. *Int Organ* 1995;49:523-53.
58. UNICEF. *Child Poverty in rich countries 2005*. Florence: UNICEF Innocenti Research Centre; 2005.
59. Elkins DJ, Simeon RE. A cause in search of its effect, or what does political culture explain? *Comp Polit* 1979;11:127-45.
60. Organisation for Economic Cooperation and Development, Development Assistance Committee. *Final ODA Data for 2005*, 2006. Available from: <http://www.oecd.org/dataoecd/52/18/37790990.pdf>